The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit our website at MolinaMarketplace.com or call 1-888-858-3973. For general definitions of common terms, such as allowed amount, balance billing, Coinsurance, Copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$7,450/Individual or \$14,900/Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. For family coverage, see instructions for additional applicable language.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive care, office visits, urgent care, inpatient hospital, skilled nursing, and preferred generic & brand drugs are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> \$7,450 individual / \$14,900 family; for <u>out-of-network providers</u> there is no coverage unless Prior Authorized by Molina Healthcare.	The <u>out-of-pocket limit</u> out-of-pocket limit is the most you could pay in a year for covered services. For family coverage, see instructions for additional applicable language.
What is not included in the <u>out-</u> <u>of-pocket limit</u> ?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>MolinaMarketplace.com</u> or call 1-888- 560-4087 for a list of <u>network providers.</u>	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at MolinaMarketplace.com

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay		Limitations, Exceptions, & Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Primary care visit to treat an injury or illness	\$30 <u>Copay</u> /visit	Not Covered	None	
If you visit a health care provider's office or	<u>Specialist</u> visit	\$65 <u>Copay</u> /visit	Not Covered	Preauthorization may be required, or services not covered.	
clinic	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your plan will pay for.	
lf you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>Coinsurance</u> /test for blood work 0% <u>Coinsurance</u> /test for x-rays	Not Covered	None	
	Imaging (CT/PET scans, MRIs)	0% <u>Coinsurance</u>	Not Covered	Preauthorization is required or Imaging services are not covered	
	Generic drugs	\$25 Copay/prescription	Not Covered	Preauthorization may be required, or	
	Preferred brand drugs	\$75 Copay/ prescription	Not Covered	services not covered. Mail-order <u>Prescription</u> <u>Drugs</u> are available at a 90-day supply and	
If you need drugs to treat your illness or condition More information about <u>prescription drug</u> <u>coverage</u> is available at <u>www.MolinaMarketplace.</u> <u>com/UTformulary2021</u>	Non-preferred brand drugs	0% <u>Coinsurance</u> after <u>deductible</u> / prescription	Not Covered	is offered at two times the 30-day retail prescription <u>Cost Sharing</u> . Depending on Tier level this will be either a <u>Copayment</u> or a <u>Coinsurance</u> . For brand name drugs with a generic equivalent, coupons or any other form of third-party <u>prescription drug</u> cost sharing assistance will not apply toward any <u>deductibles</u> or annual <u>out-of-pocket limits</u> .	
	Specialty drugs	0% <u>Coinsurance</u> / prescription	Not Covered	Preauthorization is required, or services not covered. Mail order not available.	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	0% <u>Coinsurance</u>	Not Covered	Preauthorization may be required, or services not covered.	
surgery	Physician/surgeon fees	0% Coinsurance	Not Covered	Preauthorization may be required, or	

		What You Will Pay		Limitations, Exceptions, & Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
				services not covered.	
	Emergency room care	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	Emergency room care coinsurance does not apply, if admitted to the hospital.	
If you need immediate medical attention	Emergency medical transportation	0% <u>Coinsurance</u>	0% <u>Coinsurance</u> after deductible	None	
	Urgent care	\$30 <u>Copay</u>	Not Covered	None	
lf you have a hospital	Facility fee (e.g., hospital room)	\$1,500 <u>Copay</u> /day	Not Covered	Preauthorization is required or services not covered.	
stay	Physician/surgeon fees	\$65 <u>Copay</u>	Not Covered	Maximum two days of facility copayments per inpatient admission.	
lf you need mental	Outpatient services	\$30 <u>Copay</u> /visit	Not Covered	Preauthorization is required for inpatient care or services not covered.	
health, behavioral health, or substance abuse services	Inpatient services	\$1,500 <u>Copay</u> /day	Not Covered	Preauthorization is required for inpatient care or services not covered. Maximum two days of facility copayments per inpatient admission.	
	Office visits	No charge	Not Covered	Cost sharing does not apply to routine	
	Childbirth/delivery professional services	\$65 <u>Copay</u>	Not Covered	prenatal care and first post-natal visit and certain preventive services. Depending on	
lf you are pregnant	Childbirth/delivery facility services	\$1,500 <u>Copay</u> /day	Not Covered	the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Maximum two days of facility copayments per inpatient admission.	
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	Limited to: • Up to 2 hours nursing per visit • Up to 4 hours home health aide per visit • 30 visits per calendar year <u>Preauthorization</u> is required after 7 visits for home settings, or services may be not covered	
	Rehabilitation services	0% <u>coinsurance</u> after <u>deductible</u> /visit	Not Covered	20 visits/year - Speech, Physical, Occupational Therapy combined	

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at MolinaMarketplace.com

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Habilitation services	0% <u>coinsurance</u> after <u>deductible</u> /visit	Not Covered	20 visits/year - Speech, Physical, Occupational Therapy combined
	Skilled nursing care	\$1,500 <u>Copay</u> /day	Not Covered	Limited to 30 days per calendar year. <u>Preauthorization</u> may be required, or services may be not covered.
	Durable medical equipment	0% <u>coinsurance</u> <u>after_deductible</u>	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	Not Covered	Limited to 6 months in a 3-year period. Notification only, <u>Preauthorization</u> is not required.
	Children's eye exam	No charge	Not Covered	Coverage limited to one exam/year.
If your child needs	Children's glasses	No charge	Not Covered	Coverage limited to one pair of glasses/year.
dental or eye care	Children's dental check-up	Not Covered	Not Covered	Not Applicable. Coverage can be purchased as a standalone product; it is not covered by this policy.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
Bariatric Surgery	Dental Care (Child)	Adult Routine Vision		
Cosmetic Surgery	Infertility treatment	Private Duty Nursing		
Dental Care (Adult)	 Non-emergency care when traveling outsid 	le the Routine Foot Care		
Acupuncture	U.S.	Weight Loss Programs		
	Long-Term Care	Chiropractic Care		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

Routine Foot Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Utah Department of Insurance and Financial Services (Phone: 1-877-999-6442). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also

* For more information about limitations and exceptions, see the plan or policy document at MolinaMarketplace.com

provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Utah Department of Insurance and Financial Services (Phone: 1-877-999-6442) or contact Molina Healthcare of Utah at 1-888-560-4087.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby	
(9 months of in-network pre-natal care and	ē
hospital delivery)	

The plan's overall deductible	\$7,450
Specialist Copayment	\$65
Hospital (facility) Copayment	\$1,500
Other <u>Coinsurance</u>	0%

This EXAMPLE event includes services like: Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)

Total Example Cost	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$1,500	
<u>Copayments</u>	\$4,400	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$5,960	

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a wellcontrolled condition)

The plan's overall deductible	\$7,450
Specialist Copayment	\$65
Hospital (facility) Copayment	\$1,500
Other <u>Coinsurance</u>	0%

This EXAMPLE event includes services like: Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
Deductibles	\$900	
Copayments	\$1,500	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$2,420	

Mia's Simple Fracture (in-network emergency room visit and follow up care)

The plan's overall deductible	\$7,450
Specialist Copayment	\$65
Hospital (facility) Copayment	\$1,500
Other <u>Coinsurance</u>	0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

In this example. Mia would pay:

Cost Sharing	
Deductibles	\$2,400
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,600

The plan would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Notification Molina Healthcare



Your Extended Family.

Molina Healthcare (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members and does not discriminate based on race, color, national origin, ancestry, age, disability, or sex.

Molina also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

To help you talk with us, Molina provides services free of charge, in a timely manner:

- Aids and services to people with disabilities
 - Skilled sign language interpreters
 - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
 - Skilled interpreters
 - Written material translated in your language

If you need these services, contact Molina Member Services. The Molina Member Services number is on the back of your Member Identification card. (TTY: 711).

If you think that Molina failed to provide these services or discriminated based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY: 711.

Mail your complaint to: Civil Rights Coordinator, 200 Oceangate, Long Beach, CA 90802. You can also email your complaint to <u>civil.rights@molinahealthcare.com</u>.

You can also file your complaint with Molina Healthcare AlertLine, twenty four hours a day, seven days a week at: <u>https://molinahealthcare.alertline.com</u>.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at <u>http://www.hhs.gov/ocr/office/file/index.html</u>. You can mail it to:

U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal at <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u>. If you need help, call (800) 368-1019; TTY (800) 537-7697.

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

Usted tiene derecho a recibir esta información en un formato distinto, como audio, braille, o letra grande, debido a necesidades especiales; o en su idioma sin costo adicional.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services. The number is on the back of your Member ID card. (English)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios para Miembros. El número de teléfono está al reverso de su tarjeta de identificación del miembro. (Spanish)

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電會員服務。電話號碼載於您的會員證背面。(Chinese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi Dịch vụ Thành viên. Số điện thoại có trên mặt sau thẻ ID Thành viên của bạn. (Vietnamese)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Mga Serbisyo sa Miyembro. Makikita ang numero sa likod ng iyong ID card ng Miyembro. (Tagalog)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 회원 서비스로 전화하십시오. 전화번호는 회원 ID 카드 뒷면에 있습니다. (Korean)

تنبيه: إذا كنت تستخدم اللغة العربية، تتاح خدمات المساعدة اللغوية، مجانًا لك. اتصل بقسم خدمات الأعضاء. ورقم الهاتف هذا موجود خلف بطاقة تعريف العضو الخاصة بك. (Arabic)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm. W ap jwenn nimewo a sou do kat idantifikasyon manm ou a. (French Creole)

ВНИМАНИЕ: Если вы говорите на русском языке, вы можете бесплатно воспользоваться услугами переводчика. Позвоните в Отдел обслуживания участников. Номер телефона указан на обратной стороне вашей ID-карты участника. (Russian)

ՈԻՇԱԴՐՈԻԹՅՈԻՆ․ Եթե դուք խոսում եք հայերեն, կարող եք անվճար օգտվել լեզվի օժանդակ ծառայություններից։ Չանգահարե՛ք Հաճախորդների սպասարկման բաժին։ Հեռախոսի համարը նշված է ձեր Անդամակցության նույնականացման քարտի ետևի մասում։ (Armenian)

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。 会員サービスまでお電話ください。電話番号は会員IDカードの裏面に記載されております。 (Japanese)

توجه! اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان در اختیار شما است. با خدمات اعضاء تماس بگیرید. شماره تلفن مربوطه در پشت کارت عضویت شما درج شده است. (Farsi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਮੈਂਬਰ ਸਰਵਿਸਿਜ (Member Services) ਨੂੰ ਫੋਨ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ Member ID (ਮੈਂਬਰ ਆਈ. ਡੀ.) ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਪਾਸੇ ਹੈ। (Punjabi) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich telefonisch an die Mitgliederbetreuungen. Die Nummer finden Sie auf der Rückseite Ihrer Mitgliedskarte. (German)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez les Services aux membres. Le numéro figure au dos de votre carte de membre. (French)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Cov npawb xov tooj nyob tom qab ntawm koj daim npav tswv cuab. (Hmong)

អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះក្នុងទម្រង់ផ្សេងៗគ្នាដូចជាអូឌីយ៉ូប៊ែលឬពុម្ពអក្សរជំងោយសារតែតម្រូវការពិសេសឬភាសារបស់អ្នកងោយមិន គិតថ្លៃបន្ថែម។ (Cambodian)